RESPONSE TO THE RECOMMENDATIONS
OF THE NEWBORN AND PRENATAL SCREENING
FEE BILLING PROCESS WORK GROUP
MANDATED BY SENATE BILL 1103
(CHAPTER 228, STATUTES OF 2004)

May 15, 2006

HIGH PRIORITY

Recommendation #1:

The Department needs to examine how to better educate patients on the billing process and patient costs associated with the services. Current information is missing in key areas of the billing process or misleading so that it appears that a third-party payer will cover the associated costs.
(Patient Issue #3)

(a) The patient information packet contains language stating the patient's insurance company is required to pay for the test, but no information is given regarding deductibles or co-pays. The booklet should be changed to reflect the patient's responsibility for some amount of the fee based on their insurance coverage.

Response: The Department agrees with this recommendation. Both the English and Spanish version of the patient information consent booklet have been revised to include the following wording suggested by the Work Group: "In most cases, health insurance companies and HMOs are required to cover the costs of the Expanded AFP testing after you pay any deductible or co-pay. There is an exception made for self-insured employers. Contact your health insurance provider to determine your plan's co-pay."

The next printing of the patient information consent booklet for Asian languages will also include this suggested wording.

Resources Needed: This activity was absorbed within existing resources.

Projected Implementation Timeline: The English and Spanish versions of the patient information consent booklet were updated as of June 2005. The Chinese and Vietnamese versions were completed in December 2005. The Korean language version will be completed by June 2006.

(b) The program should add a statement regarding the patient's payment responsibilities to the test requisition form as either a tear-off section or separate page the patient can take with them after the blood is drawn. This will ensure the patient will have the information with her at the time of the test and provides additional education to the patient at the time of consent.

Response: The Department agrees with this recommendation. The test requisition form has been revised to include the following language: "Contact your

insurance provider for information regarding coverage of this test, including any deductible requirement or co-pay for this service."

Resources Needed: This activity was absorbed within existing resources.

Projected Implementation Timeline: Completed February 1, 2006

(c) The Department should add the following language to the patient's bill: "Contact your insurance provider. You may have a deductible requirement or co-pay for this service."

Response: The Department agrees with this recommendation. This language has been added to the Patient Instructions on the Test Request Form (TRF). The language will also be added to the initial bill since the insurance form is also enclosed with the bill.

Resources Needed: The Department worked with the existing contractor to revise the initial bill. This was done as part of their scope of work.

Projected Implementation Timeline: The initial bill was revised in January 2006.

(d) Encourage the health plans and insurance carriers to include easily understandable information for patients on associated costs for this service in the maternity section of their explanation of benefits.

Response: The Department agrees with this recommendation, but GDB has no complete list of policymakers for all third party payers to address this issue. GDB has initiated compiling a list from our existing billing system. While the Department has no legal authority to require health plans and insurance carriers to provide this information to their clients once we have compiled the list, we will encourage providers to include this information.

Resources Needed: This requires GDB ITSS staff time. At present they are fully occupied with knowledge transfer for our SIS project, but between now and the deadline, they will compile the list and then an electronic mail merge letter will be generated and mailed.

Projected Implementation Timeline: This will be completed by May 2006.

Recommendation #2:

GDB is provided inaccurate or incomplete billing information from patients, leading to delays in both patient and health plan reimbursement. Also, GDB bills the wrong entity, delaying reimbursement from the appropriate payer.
(Billing and Claims Issue #1)

(a) Increase the number of languages on the form. This increases the likelihood of non-English speaking patients accurately filling out the form.

Response: The Department disagrees with this recommendation because implementation of this recommendation would not be cost effective. The insurance cards are currently only in English and are not in a standardized format. GDB's insurance form does currently use standardized language to comply with the clearinghouse's need in order to process the forms effectively. The use of other languages would still require that the patient translate their insurance card information onto the insurance form. This transcription may result in a similar lack of accuracy. The costs of translation and the distribution of the variety of different forms to patients are relatively high; the benefit of doing so seems relatively low.

Resources Needed: GDB would need to develop a process to determine which languages should be included on the form. This would include considering whether the outsourcing contractor could print various languages and the cost for the change. In addition, bills would have to be coded to determine the correct language and multiple billing forms would be needed that would increase postage and printing costs. If telephone or written inquiries were in different languages, GDB would need to purchase interpreter services. This would require programming changes in the billing program.

Projected Implementation Timeline: Not applicable.

(b) Amend the billing form to require laboratories and/or referring provider to attach a copy of Medi-Cal or health insurance card. Not only does this provide more accurate billing information, but also it is also less likely that mistakes will occur.

Response: The Department disagrees that the billing form needs to be amended to require laboratories, i.e., blood collection stations or physicians, to collect this information. This information is already collected through the Statewide Information System (SIS). Insurance cards and Medi-Cal cards are voluntarily included with the Test Requisition Form (TRF) and scanned into SIS

at the contract laboratories. The majority of physicians provide the Medi-Cal number on the TRF. The images are sent through SIS; GDB enters the information into the Accounts Receivable system. If all necessary information is received, readable and entered, the information is sent through an insurance clearinghouse or to Electronic Data Systems for Medi-Cal. If GDB does not receive any insurance information at the time of collection, an insurance form is included with the first bill sent to the patient so that the patient can provide this information to GDB. At that time GDB enters the correct information and regenerate an insurance bill.

Resources Needed: Not applicable.

Projected Implementation Timeline: Not applicable.

(c) Accept electronic information from doctors through doctor's clearinghouse to GDB clearinghouse. This will provide more efficient and concise billing information.

Response: The Department disagrees with this recommendation. Implementation of this recommendation would not be cost effective at this time. There are currently over 8,000 providers for the Prenatal Screening Program. For HIPPA compliance and security, electronic transfer of data from these providers would require individualized data encryption. This would be an overwhelming task to manage in an ongoing manner. A system would have to be developed to match the electronic information from the doctor's office to GDB's clearinghouse. There are HIPAA considerations to be addressed as well. Moreover, it is doubtful whether doctors or the clearinghouse would be willing to send electronic information and would do it in a timely manner since this is a capability they do not currently have. Finally, it would also add a layer of training of physicians' office staff that typically has a relatively high turnover. Accurate linking of this information to the information in SIS is difficult and at present the system is not capable of handling this additional layer of complexity. The lack of a financial incentive for providers to participate is also a concern since our experience has been that providers do not readily provide information of this type without compensation for the effort involved.

Resources Needed: Not applicable.

Projected Implementation Timeline: Not applicable.

(d) Amend the laboratory request form to require both doctor and laboratory (in separate areas on the form) to confirm accuracy of the information. This will improve the accuracy of information.

Response: The Department disagrees with this recommendation. GDB already requests that clinicians provide accurate information. The laboratory typically does not have the required information other than that supplied by the clinician. Insurance and Medi-Cal cards are currently being scanned as a means of acquiring data of higher accuracy. Images are received at GDB and data entered into the accounts receivable system. This has improved the accuracy of the information. For undelivered bills, GDB sends a letter to the provider requesting updated insurance, Medi-Cal and address information to update in the PeopleSoft Accounts Receivable module.

Resources: Not applicable.

Projected Implementation Timeline: Not applicable.

(e) Require the laboratory drawing the blood to be responsible for checking Medi-Cal or other program eligibility and correcting data when necessary. This will improve billing information.

Response: The Department disagrees with this recommendation. Specific statutory authority and enforcement capability would be needed to implement this recommendation. The Department does not plan to seek this authority at this time, because it places a burden upon the laboratory for which they are not compensated. In addition, the laboratories do not typically have access to the complete information since this is provided by the clinician as part of the test order process.

Resources: Not applicable.

Projected Implementation Timeline: Not applicable.

Recommendation #3:

Payments by a third party payer are delayed, forcing the GDB to go through additional billing notices and administrative tracking.
(Billing and Claims Issue #2)

(a) GDB needs to change their practice in order to take billing information directly off the laboratory request form. The current practice is to bill the patient directly and not use the billing information on the form, except after the fact. This would eliminate extra administrative expense and delays by getting information directly from the patient. Moreover, information will be more accurate because GDB has a copy of the payer card.

Response: The Department disagrees with this recommendation. GDB currently uses all the billing information collected on the TRF. Insurance cards and Medi-Cal cards are currently being scanned and images are received at GDB so that the pertinent information can be data entered into the Accounts Receivable system. This has improved the accuracy of the information since SIS was activated in July 2005. As an ongoing effort GDB is improving the accuracy of information received from providers.

Resources Needed: Not applicable.

Projected Implementation Timeline: Not applicable.

(b) Handle bills to patients with third party payers and to those without known insurers separately. This would improve efficiency and timeliness of payment by targeting the billing to the payer.

Response: The Department disagrees with this recommendation. There is no practical way to determine which patients are covered by third parties prior to entry of the data from the TRF into the Accounts Receivable system and/or receipt of a response from direct patient billing. Currently, GDB handles the third party payer by patient inquiries based from the billing cycles. If no insurance information has been entered prior to the patient's first bill, the patient receives her initial bill with an insurance form to complete and submit to GDB so that the billing can be redirected.

Resources Needed: Not applicable.

Projected Implementation Timeline: Not applicable.

(c) Ask the clearinghouse to switch from billing based on calendar days to billing based on business days. This gives patients more time to get information and to pay, synchronizes insurance claims payment practices with the program, and engenders less irritation on the part of patients who may feel their claims are

being paid too slowly when in actuality the claims are being paid on a timely basis by the insurer.

Response: The Department disagrees with this recommendation. The clearinghouse reformats and sends claims to insurers based on information sent by GDB. They are required to process each claim within a time-limited window. The clearinghouse does not send any follow-up correspondence. If it is necessary, follow-up statements are sent by GDB. GDB notes that many major businesses bill on a 30 day cycle so at this time GDB uses the standard business practice of 30 calendar days for the billing cycle and allows three cycles to pay. This method is efficient because GDB staff responsible for generating these statements focus their attention for a discrete period of time and then move on to other tasks. Doing this on a more piece meal basis as would be required if we are to synchronize with insurance claims practices, would be less time effective, and does not appear to provide significant patient benefit.

Resources Needed: Not applicable.

Projected Implementation Timeline: Not applicable.

MEDIUM PRIORITY

Recommendation #1:

Options for patients to pay may be too limited, thus potentially creating delays in or underpayments of the patient's portion of payment.
(Billing and Claims Issue #3)

(a) Add debit or electronic funds transfer options and/or more credit card options. This would require GDB to amend the billing form to allow for debit cards and/or add on-line payment options through a billing page added to the website. This may facilitate more timely payments.

Response: The Department agrees with this recommendation. GDB currently has a Master Service Agreement with NOVA to accept VISA and Mastercard. The current contractor can also accommodate American Express and Discover credit cards; however, a separate Master Service Agreement for each card will be needed to provide these services.

Resources Needed: In order to accept additional credit cards, revisions must be made to the billing form and telephone voice information. Updated software

for Lockbox and GDB would also be needed. This will require that existing GDB business service staff negotiate a revised service agreement.
Projected Implementation Timeline: July 2006.

(b) Amend the laboratory request form to clarify the patient's responsibility for co-pays and deductibles. Not only will the patient have the information with her at the time of the test, but also this will provide additional education to the patient at the time of consent.

Response: The Department agrees with this recommendation. The test requisition form was revised in January 2006 to include the following language: "Contact your insurance provider for information regarding coverage of this test, including any deductible requirement or co-pay for this service."

Resources Needed: This activity was absorbed within existing resources.

Projected Implementation Timeline: This was completed in January 2006.

(c) Improve collection of delinquent accounts by piloting the use of a collection agency. This may improve collection in situations where the patient would not have a tax refund to withhold as a last option. In addition, the threat of an action against a patient's credit rating may increase reimbursements.

Response: The Department agrees with this recommendation. Currently, GDB intercepts a patient's tax refund through the Franchise Tax Board (FTB) offsets. A message is noted on the patient's sixth bill indicating the account may be submitted to the Franchise Tax Board if unpaid by the due date shown on the final notice. GDB bills through FTB for two years. After two years, GDB sends it to a collection agency. GDB contracts with collection agencies that retain 33 percent of collections. Less than five percent of these bills will be collected after two years. This experience does not encourage the effort, but revision of the timing of forwarding delinquent bills to a collection agency may improve collections.

Resources Needed: Existing GDB business support staff will need to develop and negotiate the revised scope of work. GDB ITSS staff will need to develop the computer report of overdue accounts.

Projected Implementation Timeline: December 2006.

(d) Allow for prepayment of the patient's portion of the bill at the time of service. Having reimbursement collected up front would negate the need for an expensive and protracted billing process.

Response: The Department disagrees with this recommendation. Blood collection stations and physicians are not set up to function as collection agents for the State. Many patients will not know how much their insurance company would pay; patients would be unclear what services they are paying for and to whom; the physicians will likely object to having to maintain additional books on revenue and forwarding the revenue collected to GDB; there are tax records to be maintained to ensure this is not considered income for physicians. Moreover, there can be an issue if the payment received was not identified to the patient correctly. This can cause confusion and frustration on the part of patients. It could also result in a delay in attributing the payment to the correct patient since we know that computer data input at these sites is imperfect. If GDB were to do this it would require establishing an additional collections system with new and untried partners. GDB does not view this as readily doable or as having a high likelihood of success.

Resources Needed: Not applicable.

Projected Implementation Timeline: Not applicable.

Recommendation #2:

GDB is not a contracting or "preferred" provider under health plan and insurer contracts, thus the patient pays out-of-network co-payments.
(Billing and Claims Issue #4)

Encourage health care service plans and health insurers to deem GDB as an in-network provider. This may reduce the percentage of the patient's portion to be collected by GDB, lessen the financial barriers for getting the screening, and may reduce patient confusion based on the expectation that they are referred by their doctors to an in-network service.

Response: The Department will explore this recommendation further to assess the number of patients paying out-of-network co-payments and the receptivity of health plans to designate the GDB as a "preferred provider". However, GDB has no means to demand it at this time. It should be noted that the Department currently cannot negotiate or contract for a different fee from that in the regulation, and most in-network provider services are based upon contractual or

capitated amounts. It appears as though if GDB accepts the contractual or capitated amount, GDB would not know the volume of patients that may fall into this category. GDB would be required to collect the difference between the capitated amount and the regulated fee from patients. This significantly increases the effort needed to collect the revenue.

Resources Needed: Resources needed to examine this proposal will be absorbed by existing staff.

Projected Implementation Timeline: Completion of investigation by October 1, 2006.

LOW PRIORITY

Recommendation #1:

The Department should examine the process of non-provider collection of co-pays. This is confusing to patients who may not know the extent of their responsibility for fees associated with the service and laboratory work.
(Patient Issue #1)

The work group recommends the Department continues with the status quo, but improves notification of responsibilities to patients. This will inform the patient of her responsibility up front while increasing the patient's knowledge of her responsibility for fees, and increase the collection of payments to the program. This alternative keeps the good features already within the program billing procedure while making necessary changes to improve payment. This change will be relatively easy to administer.

Response: The Department agrees with this recommendation and has implemented it. The test requisition form now includes the following language: "Contact your insurance provider for information regarding coverage of this test, including any deductible requirement or co-pay for this service."

Resources Needed: This activity was absorbed within existing resources.

Projected Implementation Timeline: This change was made in February 2006.

Recommendation #2:

The Department should consider patient incentives to pay on a timely basis. Currently there is no incentive for the patient to pay bills on time. The cost to the patient remains the same throughout the three-year billing cycle.
(Patient Issue #2)

The work group recommends a statutory change to add penalties for late payment to a patient's bill. This would allow the program to recover additional costs for billing and collection of unpaid fees. It is more likely the bill will be paid in a timely manner by the patient.

> **Response:** The Department disagrees with this recommendation at this time. This requires a policy change that would necessitate a legislative initiative and careful crafting to ensure that the desired outcome is achieved. This recommendation raises a number of concerns, including among other things, how it might act as a disincentive to utilize the tests and how a penalty would apply to all women with overdue accounts even if the delay is outside their control. Due to its low priority ranking and other competing priorities in the GDB, the Department will not pursue this proposal at this time. GDB is willing to re-examine this recommendation once the other more pressing improvements have been implemented.
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> **Resources Needed:** Not applicable.
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> **Projected Implementation Timeline:** Not applicable.

Recommendation #3

The Department should give hospitals advance notice of fee increases and decreases.
(Hospital Issue #1)

The work group recommends that the Department advise hospitals in advance whenever a fee increase is being considered. Further, the Department should provide a minimum of 90 days advance notice prior to implementation of a fee increase or decrease. This would enable hospitals to use this information as part of their contract negotiations with health plans.

> **Response**: The Department agrees with this recommendation. GDB will make every effort to provide at least 90 days advance notice prior to the effective date of a fee increase or decrease that is implemented through the typical regulatory process. GDB may not be able to provide 90 days advance notice for fee changes implemented through other means.

Resources Needed: This can be absorbed with existing staff.

Projected Implementation Timeline: This can be instituted with the next fee change proposal.